Editorials

Death and Dying— A Public or Private Matter?

ELSEWHERE IN THIS ISSUE a medical student wrestles with the principles promoted by The Hemlock Society, which advocates positive euthanasia at the hands of physicians, albeit in compliance with the understood desire of a terminally ill patient and all others who may properly be concerned. This raises many important issues, none of which is likely to go away soon. For the first time, and to the extent it ever occurred at all, what was a very personal and intimate matter between doctor and patient is now becoming one of public concern and is sure to generate public debate.

Physicians are revulsed by the idea of contributing purposely or willingly to the death of a patient. Yet, we all know that compassion may lead to an understanding with a patient and family, particularly within the framework of a close and long-standing doctor-patient relationship, that will in one way or another hasten the death of a suffering and terminally ill patient for whom there is no hope. The acts have more often been ones of omission rather than commission, although not always, as with a decision to terminate life support systems. There is a fine line between a decision such as this and active euthanasia administered by a physician, but it is a line that physicians are reluctant to cross and have not crossed.

The scene and the drama are now beginning to shift into the public arena. There are a growing number of persons who are appalled by the suffering of many patients who are terminally ill when it is within the power of their physicians or of society to end this apparently needless suffering, much as a veterinarian might end the suffering of a beloved family pet when its life expectancy is short and its quality of life irreversibly gone. Often, these persons are driven by their own first-hand experience with long, expensive, and—to them—unnecessarily prolonged suffering in a member of their family. This has profoundly affected many people and has led to such things as living wills, durable powers of attorney, and now, The Hemlock Society.

More crass social, economic, and even political considerations are beginning to touch upon the scene and the drama of death and dying. It is now virtually routine to try to revive a dying person of any age or with any fatal illness by attempting cardiopulmonary resuscitation, if nothing else. This is accepted, even expected, by present day society. In many cultures, including our own, there is some special reverence for the elderly, but how much reverence will or should there be when it comes to allocating increasingly expensive and scarce resources to perpetuating the lives of those whose productivity and quality of life are gone, and who do not wish to live any longer regardless of the cost to them or to others, especially when it is also a fact that vast numbers of younger Americans who have their full lives ahead of them do not have sufficient resources available for the health care they need? So far, the voting power of the elderly has been an important political factor in determining this distribution of national health care resources. And then, there is the harsher impact of health care economics. For better or worse, the "bottom line" is beginning to dominate more and more of the health care in this nation. It is well known, and worth noting, that Medicare data show that most of the major health care costs are incurred in the last year or so of life. One may ask, and some already have, how cost effective is much of this terminal care, and what is being achieved at what expense? Again, from a crass economic standpoint, a sudden death is least costly and, therefore, most cost effective, since little or no health care is needed. Next most cost effective would seem to be a shorter terminal illness and a comfortable and pain-free death for a fatally ill patient with very little for which to live. In all of this one can easily foresee the spectre of social, economic, political, and even family pressures on the ill and the elderly to "voluntarily" seek active euthanasia if this were ever to receive widespread social acceptance.

It remains to be seen whether we are ready to accept the view of The Hemlock Society. If and when an initiative appears on the California ballot—and there is reason to believe that one may soon qualify—there will then be a test of public opinion. In any case, and whatever the outcome, death and dying are becoming much less private and much more public matters. Physicians cannot help but be deeply concerned. The issues that are raised strike at the heart and soul of what medicine is all about.

MSMW

The Treatment of Scoliosis

THE ARTICLE "Adolescent Idiopathic Scoliosis" by Rinsky and Gamble elsewhere in this issue is thorough, well documented, balanced, and informative. It is about a disorder of great concern to parents, pediatricians, and orthopedists. At the outset the authors correctly state that the diagnosis of scoliosis is straightforward and is made on clinical and radiographic examination. The epidemiology has been explained using data provided from school screening programs. The precise etiology evades us, although there are some tantalizing experimental and clinical phenomena that point to one cause or another. However, it is in the area of nonoperative and, to a lesser extent, operative treatment that significant clinical controversy exists.

A general historical survey of the evolution of the treatment of adolescent idiopathic scoliosis may help focus the current dilemma that many treating orthopedists face. Prior to the late 1940s, there was no reasonable nonoperative means of preventing progression of a scoliosis curve. Prolonged casting and bed rest were infrequently employed. Patients and parents were advised that surgical correction was a last and dangerous resort. Nobody understood the natural history of the disorder. The patient whose curve unpredictably increased was advised that some day a surgical procedure would become absolutely necessary and the risk, at that future date, acceptable.

In the 1950s and 1960s, the Milwaukee, Pasadena, and other braces were used with considerable success to prevent progression of the curve. Surgical treatment was still plagued with complications and was performed only in centers by a relatively few expert spinal surgeons. Reliable natural history data remained unavailable. Only moderate and large curves were being treated.

In the 1970s, in response to the patients' cosmetic and functional objections to the Milwaukee brace, orthopedist-orthotist teams developed many varieties of underarm braces. Almost simultaneously, the widespread adoption of school